

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

663-043255

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 6326

STATE FILE NUMBER

VS 300  
Rev. 4/59

1 6008

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USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF  
Laurence Hayes MEDICAL CERTIFICATION

FILED DEC 1 1963

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>CLAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KAN. CITY, MO.</b>		c. CITY OR TOWN <b>KAN. CITY, MO.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>NURSING GUARDIAN ANGEL HOME</b>		d. STREET ADDRESS (If outside, give location) <b>4001 N. WINN RD.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NETTIE</b> Middle <b>E.</b> Last <b>SCHORLING</b>		4. DATE OF DEATH Month <b>11</b> Day <b>19</b> Year <b>1963</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-6-1879</b> 9. AGE (last birthday) <b>84</b>
10a. FEMALE OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DICKINSON CO. KS.</b>	
11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>BRADLEY WARNOCK</b>		13b. MOTHER'S MAIDEN NAME <b>NANCY E. SHRY</b>	
14. NAME OF HUSBAND OR WIFE <b>HENRY C. SCHORLING</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b>	
16. SOCIAL SECURITY NO. <b>1516-515-TERP</b>		17. INFORMANT <b>CLIFFORD SCHORLING K.C. No. No.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Generalized arteriosclerosis years</b> DUE TO (c) <b>None</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Prior Cerebral thrombosis &amp; hemiplegia</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>March 1959</b> , to <b>October 1963</b> and last saw her alive on <b>Oct. 1963</b> Death occurred at <b>6:45 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Laurence Hayes M.D.</b>		22b. ADDRESS <b>8640 N Oak KC 55 MO</b>	
22c. DATE SIGNED <b>11-20-63</b>		23a. BURNAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE <b>11-21-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAH</b>	
23d. LOCATION (City, town, or county) <b>KAN. CITY, MO.</b>		24. FUNERAL DIRECTOR ADDRESS <b>D.W. NEWSOMERS-SONS N.K.C.</b>	
25. DATE RECD. BY LOCAL REG. <b>11-21-63</b>		26. REGISTRAR'S SIGNATURE <b>Bessie Smith</b>	

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Student \_\_\_\_\_  
Signature of Student Embalmer \_\_\_\_\_

**Signed**

**Licensed Embalmer No**

**P. O. Address**

If this body is not embalmed, fact should be so stated above.